

cific procoagulants, whose concentration and effects are more prominent close to their site of origin. Both mechanisms have been demonstrated in patients with adenocarcinoma of the pancreas.² However, reports of thrombosis in patients with mesothelioma are much rarer than in patients with adenocarcinoma of the pancreas or lung, for example, which suggests that the first mechanism is the more likely in the case we described;¹ the chest CT shown in our report is consistent with this hypothesis. The surgery report did not allude to the state of the veins, and, unfortunately,³ an autopsy was not authorized. As for our description of Virchow's triad, use of the word "epithelial" was a typographic error, and the text should have referred to "endothelial damage" (on page 465, third column).

The case reported by Mehlika Isildak and associates is an additional vivid reminder that cancer-associated thrombosis can affect veins at almost any site; it also emphasizes the greater risk with more advanced disease.¹ However, thrombotic complications in mesothelioma remain an unusual occurrence in both early⁴ and advanced disease. Interleukin 6 (IL-6) may indeed be produced by mesothelioma and other tumours.⁵ It affects not only the number of platelets but, more important, their function. Platelets responding to IL-6 have increased sensitivity to activation by thrombin and increased procoagulant activity, which may be further enhanced by the elevated levels of fibrinogen and plasminogen activator inhibitor (which suppresses fibrinolysis) caused by IL-6 and other inflammatory mediators.⁶ The exact relevance of these observations to thromboembolism in vivo remains unproven.

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Kickbacks and self-referral

Sujit Choudhry and associates¹ raise some excellent points in their discussion of the unethical nature of physician kickbacks and physician self-referral. An additional related behaviour is on the horizon for physicians in many provinces.

Electronic medical records and clinical management systems are now being promoted by federal and provincial authorities as a valuable component of care. One of the many functions currently being touted as desirable in a clinical management system is direct communication between the prescribing doctor and the patient's pharmacy for both new and repeat prescriptions.

For the vast majority of prescribing physicians and pharmacists, the ability to send a prescription to a pharmacy "at the touch of a button" will be a welcome relief from repetitive, illegible, hand-written prescriptions. For a few doctors and pharmacists, this function will represent an opportunity for hidden financial gain (through a kickback).

Time could be well spent asking questions about direct connections between a prescribing physician and a pharmacy. Provincial regulating authorities for both pharmacists and physicians should examine the risks and benefits of this functionality. They should also determine what reporting and control mechanisms are needed to

minimize the temptation of a destructive conflict of interest.

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Sujit Choudhry and colleagues¹ are to be congratulated for raising the troubling issues of physician kickbacks and self-referrals.¹ The Medical Reform Group, of which I am a member, agrees that these practices are ethically dubious and ought to be much more closely regulated.

One simple way to limit kickbacks and self-referrals would be to ban investor-owned independent health facilities from operating within the publicly funded health care system. Kickbacks and self-referrals exist chiefly to increase profit. Disallow profit, and these practices would probably wither away.

There is another reason to consider banning investor-owned independent health facilities: quality. In the United States at least, investor-owned hospitals² and dialysis centres³ are associated with higher mortality rates than private, nonprofit facilities. Similarly, in a study comparing for-profit and nonprofit health maintenance organizations in the United States, the nonprofit organizations outperformed the for-profit ones on all of the 14 quality-of-care indicators that were assessed.⁴ In the Canadian context, for-profit independent health facilities are most common in the diagnostic services (e.g., laboratory testing and imaging) and rehabilitation (e.g., physiotherapy) sectors. Given the US data (there are none from Canada), there is no reason to assume that the services they provide are as good as those provided by nonprofit operators.

As one highly respected health care analyst has written in *CMAJ*, “Canadians [should] re-embrace the core concept of a universal health care system in which the vast majority of services are provided by non-profit institutions with public accountability.”⁵

So yes, we should ban kickbacks and limit self-referrals. But if we really want to get to the root of the problem (and perhaps improve quality at the same time), we should encourage policy-makers to prohibit for-profit independent health facilities from providing medically necessary care.

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Elective cesarean section

It was with utter dismay and surprise that I read Mary Hannah’s commentary on planned elective cesarean section.¹ Given that there has never been any scientific proof of benefit from unindicated surgery, how can the literature for indicated procedures be used to justify our willingness to acquiesce to the wishes of the consumer? And just because indicated procedures have low rates of complications and appear safe, we should not use those data to bend to

current trends in consumerism. Are we physicians so afraid of disappointing the consumer that we are willing to perform unnecessary procedures? I find it rather hypocritical that we misuse and contort the literature to justify this approach and then turn around and call ourselves scientists practising evidenced-based medicine. If we want to practise what amounts to cosmetic surgery, then by all means, let’s do so and bill patients for these services independently.

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Mary Hannah concludes her commentary on elective cesarean section¹ by suggesting that if, after appropriate counselling, a woman continues to perceive that the benefits of such a procedure outweigh the risks, her health and welfare “will be promoted by supporting her request.”

In this regard, it is important that all evidence on the benefits and harms be presented to the prospective mother. The UK’s National Institute of Clinical Excellence (NICE), which provides authoritative, robust and reliable guidance on current “best practice” to patients, health care professionals and the public,² is currently developing clinical guidelines on cesarean section,³ expected to be released in April 2004 [the guidelines have now been published; see *CMAJ* 2004;170(12):1779.—Editor].

According to the draft document (page 27),³ “maternal request is not on its [sic] own an indication for [cesarean section],” and “pregnant women should

be supported in whatever decision is made following these discussions.” The draft (pages 19–21) provides current evidence on length of stay, abdominal pain, perineal pain, postpartum hemorrhage, infection, breastfeeding, bladder and urinary tract injuries, need for further surgery, risk of thromboembolic disease and many other clinical outcomes, the majority of these data favouring vaginal birth over cesarean section.

Women should have a right to exercise their choice on the mode of delivery even when there are no clinical indications for cesarean section. However, providing this procedure in a publicly funded system such as the UK’s National Health Service would increase the overall cost, and the opportunity cost thus incurred might deny services that would be of benefit to other users of the service.

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Competing interests: The author is a firm believer in and advocate of evidence-based health care and is training in public health in the UK National Health Service.

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I was disturbed to read Mary Hannah’s commentary¹ outlining the possibility of the Society of Obstetricians and Gynaecologists of Canada (SOGC) supporting the option of medically unnecessary cesarean sections. I am disappointed that cesarean section would be offered when little consideration is given to options at the other end of the spectrum.